Changes in threat-related cognitions and experiential avoidance in group-based transdiagnostic CBT for anxiety disorders

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Abstract
Group-based Transdiagnostic Cognitive Behavioral Therapy (TCBT) for anxiety disorders aims to target common factors to produce beneficial effects on multiple anxiety disorders at once. While there is growing evidence that various anxiety disorders can be effectively treated by this approach, the common factors contributing to these treatment effects are not well delineated. In a sample of 48 Veterans who completed Group-based TCBT, the current study examined change in threat perception and change in experiential avoidance pre to post-treatment and as potential mediators of changes in negative affect and personalized fear ratings. Results indicated that both threat perception and experiential avoidance were significantly reduced during treatment. Additionally, reductions in both threat perception and experiential avoidance significantly predicted reductions in negative affect and fear ratings. When change in threat perception and change in experiential avoidance were examined simultaneously, both remained significant predictors of changes in negative affect though only experiential avoidance predicted changes in fear ratings. Thus, both reductions in threat perception and experiential avoidance may mediate the broad treatment effects observed in group-based TCBT. Directions for future research are discussed.

1. Introduction

Cognitive behavioral therapies (CBTs) targeting panic disorder (PD), generalized anxiety disorder (GAD), and social phobia (SP) have well-established efficacy (Butler, Chapman, Forman, & Beck, 2006; Hoffmann & Smits, 2008; Norton & Price, 2007). Additionally, CBTs are particularly effective in the treatment of posttraumatic stress disorder (PTSD) and obsessive compulsive disorder (OCD), which were previously categorized as anxiety disorders in DSM-IV (American Psychiatric Association, 2000). However, the broad dissemination of these treatments has been limited due in part to their specificity – treatments designed to target a single disorder. Training to proficiency in multiple distinct protocols can pose a significant financial and training burden, which can be a significant deterrent to greater implementation of these treatments (Barlow, Allen, & Choate, 2004). To address this barrier, there has been a recent interest in developing transdiagnostic treatments whereby multiple anxiety disorders can be treated using a single protocol.

Transdiagnostic CBT (TCBT) for anxiety disorders was developed on the premise that anxiety disorders share many common causal and maintaining factors (McEvoy, Nathan, & Norton, 2009). Treatment techniques targeting these common factors can have broad applicability, making it possible for individuals with different anxiety disorders to benefit from a single treatment. Group-based TCBT for anxiety disorders allows individuals with different anxiety disorders to be treated within a single group, which can improve access to treatment for individuals with any anxiety disorder (Norton, 2012). There is growing evidence that TCBT, delivered in either individual or group format, is an efficacious treatment for several anxiety disorders, including GAD, PD, and SP (Reinholt & Krogh, 2014). These findings support the broad applicability of TCBT to treat anxiety disorders. However, the common factors contributing to these broad treatment effects have yet to be clearly delineated.

Initial investigations of common factors contributing to the treatment effects of TCBT have focused on the role of negative affectivity. Negative affectivity, the tendency to experience negative emotional states, such as fear, anxiety, depression, and guilt (Clark & Watson, 1991), is a well-established risk factor for anxiety disorders (e.g., Brown, Chorpita, & Barlow, 1988). Changes in negative affect have been found to largely account for changes in anxiety symptoms experienced during individual (Sauer-Zavala et al.,...
2 and group-based TCBT (Talkovsky & Norton, 2014). However, establishing negative affectivity as a mediator of treatment effects in TCBT are largely non-informative regarding the therapeutic processes and associated techniques that contribute to change during TCBT (Ormel, Rosmalen, & Farmer, 2004). Examining factors that contribute to changes in negative affect may offer better clues as to how to account for, and potentially enhance, the broad treatment effects observed during TCBT.

Cognitive accounts of anxiety posit that exaggerated perceptions of threat play a maintaining role in all anxiety disorders. Perceptions of threat are determined by the joint product of subjective estimates of the probability of negative events and perceptions of the cost, or aversiveness, of those negative events (Beck, 1976; Carr, 1974). Anxiety disorders may be characterized by exaggerated estimates in both probability and cost estimates of negative events. Consistent with this idea, elevated estimates of the probability and cost of certain types of negative events have been demonstrated for several different anxiety disorders including GAD (Butler & Matthews, 1983), SP (Foa, Franklin, Perry, & Herbert, 1996), PD (Uren, Szabo, & Lovibond, 2004), and Agoraphobia (AG; McNally & Foa, 1987), as well as PTSD (White, McManus, & Ehlers, 2008), and Acute Stress Disorder (Warda & Bryant, 1998).

CBT for anxiety disorders may work in part through reducing exaggerated threat perceptions. Exposure techniques are posited to decrease exaggerations in both the probability and cost estimates of negative events through activation of the fear structure and the incorporation of disconfirming information, a process termed corrective learning (Foa & Kozak, 1986). Cognitive restructuring techniques, such as generating plausible alternative, less threatening outcomes, may work directly to reduce exaggerated threat perceptions (Bentz et al., 2009). Various studies of CBT for anxiety disorders have examined reductions in probability and cost estimates over the course of treatment, especially in relationship to symptom improvement. McNally and Foa (1987) demonstrated that CBT reduced probability and cost estimates of arousal symptoms in individuals with AG to levels equivalent to normal controls. Individuals with SP reported reduced probability and cost estimates of negative social events following CBT and such reductions were significantly associated with the degree of symptoms improvement (Foa et al., 1996; McManus, Clark, & Hackman, 2000). White et al. (2008) similarly demonstrated that CBT reduced probability and cost estimates of future traumatic events in individuals with PTSD, and that these reductions correlated with reductions in PTSD symptoms. Thus, reductions in exaggerated threat perception may be a common process in the successful treatment of a variety of anxiety disorders through CBT.

CBT for anxiety disorders may also affect change through alterations in experiential avoidance. Experiential avoidance is defined as an unwillingness to remain in contact with negative internal experiences, including unpleasant emotions, thoughts, and bodily sensations, through direct attempts to alter the form or frequency of those experiences (Bardeen, Fergus, & Orcutt, 2013; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Experiential avoidance has been associated with various forms of psychopathology (Chawla & Ostafin, 2007), including anxiety and trauma-related disorders (Bluett, Homan, Morrison, Levin, & Twowig, 2014). Experiential avoidance has traditionally been discussed as the primary target of Acceptance and Commitment Therapy (ACT) based treatments (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). However, CBT for anxiety disorders is also expected to lead to reductions in experiential avoidance though the application of exposure techniques to previously avoided and suppressed internal experiences and the stimuli that elicit them (Arch & Craske, 2008). Consistent with this idea, Gloster et al. (2014), in a study that examined temporal mediators of CBT for panic disorder with agoraphobia, demonstrated that changes in experiential avoidance predicted changes in panic symptoms during the exposure phase of treatment. Also, in a study of mixed anxiety disorder diagnoses, Arch et al. (2012) found that reductions in experiential avoidance similarly predicted outcome following both CBT and ACT. Thus, alterations in experiential avoidance may be associated with the successful treatment of a variety of anxiety disorders during CBT.

The current study uses data from an open trial on group-based TCBT for anxiety disorders in a sample of Veterans (Espejo et al., 2015). In that study, it was demonstrated that Veterans participating in the treatment experienced significant reductions in broad negative affect and in personalized fear ratings. The current study had three aims: 1) to examine whether threat perception (estimates of the probability and cost of negative events) were significantly reduced following group-based TCBT; 2) to examine reductions in experiential avoidance during group-based TCBT; and 3) to examine whether reductions in threat perception and experiential avoidance are associated with reductions in negative affect and personalized fear ratings. Based on prior research, it was hypothesized that both threat perceptions and experiential avoidance would decrease over the course of treatment. It was further hypothesized that reductions in threat perception and experiential avoidance would be associated with reductions in negative affect and fear ratings.

2. Methods

2.1. Participants

The current study included veterans who participated in group-based TCBT for anxiety disorders at the VA San Diego Health Care System between September 2013 and August 2014. Seventy-two Veterans initiated group treatment during the study period (10 groups total), of whom 54 completed treatment (75.0%), defined as attending at least 8 sessions including the final session. Among those completing treatment, six were excluded from the current study due to non-consent (N=2) or incomplete data (N=4). The final 48 participants were predominantly male (13 females), age 24–70 (M=45.3, SD=12.6), and racially and ethnically diverse: 21 identifying as Caucasian (43.8%), 15 African American (31.3%), 6 Asian (12.5%), 4 Hispanic/Latino (8.3%), 1 Native Hawaiian/Pacific Islander (2.1%), and 1 unanswer (2.1%). Treatment completers did not differ from non-completers by age, gender, race/ethnicity, number of anxiety disorder diagnoses, or co-occurring depressive disorder (p>0.60).

2.2. Procedures

Veterans were initially referred to the Anxiety Disorders Clinic (ADC) from primary care clinics or another mental health clinic at the VA San Diego Health Care System for the treatment of a primary (or co-primary) anxiety disorder, PTSD, or OCD. Veterans seeking treatment for a primary diagnosis of PTSD related to the military or sexual trauma were referred to other specialty clinics as were veterans with uncontrolled substance dependence within the past three months. Approximately 45 Veterans are referred for services in the ADC per month with about 50% of those Veterans presenting to an individual treatment planning session. During these sessions, diagnoses are confirmed via structured intake assessment and various treatment options are discussed, including group-based TCBT. Veterans receiving services in the ADC were invited to participate in research without it impacting the services they received in the clinic. All study procedures were approved by the VA San Diego Research Service and the University of California, San Diego, Human Research Protection Program. Further details of the study procedures are described in Espejo et al. (2015).
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